STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010250	A. BUILDING: _____ B. WING _____	C 04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY MANOR	2345 NORTH SEMINARY STREET GALESBURG, IL 61401

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S 000	Initial Comments Complaint Investigation: 2122245/IL132389	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three

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S9999	Continued From page 2 months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident's bed was in low lying position for one (R1) of three residents reviewed for falls. This failure resulted in R1 sustaining a right-sided subdural hematoma and scattered subarachnoid hemorrhages and subsequently death. Findings Include: R1's care plan dated 2/20/21 documents, Problem: Resident (R1) at risk for falling r/t (related to) recent illness/hospitalization and new environment. (R1) has hx (history) of falls. (R1) has a dx (diagnosis) of dementia, poor safety awareness and is impulsive. Res (resident) has impaired balance and mobility related to weakness and confusion ...." Goal: Resident will have decreased risk for injury related to fall this quarter. Approach: Low bed and scoop mattress." R1's fall risk assessment dated 3/21/21 documents R1 as a high fall risk. On 4/08/21 at 10:00 AM, V6, Care Plan Coordinator, stated "One of the fall interventions for (R1) was for the bed to be in a low position. (R1) has a history of getting up from his bed and walking without assistants or calling for help" R1's medical record documents R1 fell four times	S9999		

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S9999	Continued From page 3 with two falls, 3/21/21 and 4/05/21, resulting in serious injuries. R1's medical record dated 3/21/21, documents "(R1) fell hitting face. Laceration, broken teeth and bruising with skin tear. Sent to emergency room for evaluation and sutures." R1's hospital records dated 3/21/21 documents "Imaging report: computerized tomography (CT) scan brain. Impressions: No evidence of acute intracranial hemorrhage." R1's medical record dated 4/5/21 documents "At 7:15 PM, Certified Nursing Assistant (CNA) called this nurse to (R1)'s room. When entering the room, (R1) was noted to be laying on his left side on the floor by his bed. Bed was up in a normal position and call light was not on. (R1) stated "I fell out of my bed." (R1) noted to have laceration to back side of left head. Pressure applied and bleeding did slow down. On call doctor notified and new order to send to emergency room for treatment." R1's hospital record dated 4/5/21 at 9:36 PM documents "Imaging report: CT scan brain. Findings: Scattered subarachnoid hemorrhages are seen within the right temporal lobe and frontal lobe. Hemorrhagic contusions in the right temporal parietal lobe are visualized. There is a small right-sided subdural hematoma measuring up to seven millimeters. Bilateral periventricular white matter changes are seen suggesting microangiopathic ischemic changes." R1's hospital records dated 4/6/21 documents "(R1) presents as a transfer from outside hospital after unwitnessed fall at the nursing home. He was found to have a subdural hematoma as well	S9999		

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S9999	Continued From page 4 as subarachnoid hematoma. during transfer, he had two seizures." On 4/8/21 at 9:00 am, V2, Director of Nursing (DON), stated "Mobile x-ray came in to get an x-ray of (R1)'s hand and left his bed in the raised position. (R1) fell out and sustained a subdural hematoma." On 4/8/21 at 12:25 AM, observation of R1's bed appeared approximately six inches from floor. V2, DON, stated "That's the low-lying position. (R1)'s bed was in a raised position at the time of the fall." Observation of bed in raised position is approximately three feet off the floor. On 4/8/21 at 12:35 PM, V1, administrator, stated "The x-ray tech took an x-ray of R1's right hand, exited the room and left R1's bed in the raised position. R1 wound up falling out of the bed causing a head injury." On 4/9/21 at 11:09 AM, V3, CNA, stated "I was working on 4/5/21 assigned to (R1)'s group. That evening I got (R1) cleaned up and placed him in bed. The mobile x-ray technician came in to take an x-ray of (R1)'s hand and asked me to raise the bed to a high position, so I raised (R1)'s bed up for the X-ray. It's not mandatory to stay in the room with them, but I always do. During the x-ray, a call light in another room went off and so I asked the x-ray technician if it was ok to answer the call light. He said yes. So, I left the room to answer another call light. When I came out of the room from answering the call light, I heard (R1)'s roommate hollering "We need help." When I entered (R1)'s room, the x-ray technician was gone, (R1) was lying on the floor between the beds, and the bed was still in the raised position."	S9999		

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S9999	Continued From page 5 On 4/13/21 at 1:55 PM, V5, x-ray technician, stated "I was called in to take an x-ray of (R1)'s hand. When I got there a nurse told the CNA to give me a hand. We walked into the room and the bed was in a low position, I didn't know where the controls were, so I asked the CNA to raise the bed in order for me to get my machine under the bed. The CNA raised the bed. I told the CNA I was good because I only had three x-rays to get. She left the room; I finished the x-ray and left the room. I did not put the bed back down because it wasn't that far off the floor. When I left, the CNA that was in the room with me, was in the hallway, so I told her I was all done and needed let off the unit because it's a locked unit. She let me out and I left." On 4/12/21 at 9:00 AM, V1, Administrator stated "We don't have a fall prevention or fall risk policy. We do the fall assessment and put the fall interventions on the care plan." V1 also stated that there currently is no policy addressing x-ray technicians while on site. R1's medical record dated 4/11/21 documents that (R1) expired in the hospital. R1's death certificate lists Date of Death April 10, 2021; cause of death a. Traumatic Subdural Hematoma with Subarachnoid Hemorrhage b. Fall. (A)	S9999		